

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 4-30-03.

I. DISPUTE

Whether there should be reimbursement for CPT Codes: 99352H1-H4 and 99499H1- H4 rendered from 5-1-02 through 5-31-02.

II. FINDINGS

The respondent contends that for dates of service 5-1-02 to 5-31-02...___ billed Carrier a grand total of \$71,820.50 for home health care services...Carrier has already reimbursed ___ \$38,326.00 for the disputed dates of service. The total amount in dispute is \$33,494.50.

The respondent denied reimbursement based upon “F – This charge has been reimbursed according to the appropriate fee schedule or usual and customary value; M – No MAR; Unbundling; Home Health Agency Services.”

On 2-27-03, the requestor stated that,

“the charges are for personnel required to provide healthcare for ___. ___ is a Quadriplegia C1-C4, Complete (344.01) and required skilled nursing care twenty-four hours a day.

The HCFAs are billed by each individual healthcare worker who worked a shift of care during each month. For each caretaker two codes are used to bill a shift: 99352 for the first hour of the shift and miscellaneous code 99499 for the remainder of the shift as per the specific instruction of ___ and ___, CNA representatives.

For the EOBs received, in every instance the 99352 is being denied as unbundling and the 99499 fee is greatly reduced. ___ insisted that LF Rose, Inc. bill in the manner were are continuing to bill today...Rates and levels of care were further discussed and approved on November 14 and 15, 2001 at a CNA conference...For the first year and a half you paid our claims without any problems...”

On 4-25-03, the requestor stated that,

“A company was formed, LF Rose, Inc., to provide care for ___. Since he is the only patient, no home health care license was required. The carrier was asked and rules were searched. There was no requirement set by the TWCC rules for the company to be licensed, there was no requirement by the State of Texas, and the insurance company – through its Adjustor, ___, its case manager, ___, and its actions of providing payment from November 1999 until May 2001 – all approved the use of LF Rose, Inc. as the home health provider for ___. It is determined by two independent agencies and by ___’s

doctor that ____ needs are for two people 24 hours. Due to the skilled nature of ____'s care the independent agencies determined one must be an RN...the second person (as per the home health agencies) must be an LVN. An estimate of costs is received. The least expensive is \$60.00 per hour for an RN and \$45.00 per hour for an LVN.

LF Rose, Inc. agrees with the CNA case manager, ____ to provider for \$5.00 per hour less than the least expensive agency..."

The requestor submitted a standard rate billing by home health agencies located in the Denton/DFW area. The rates ranged from \$2250.00/day to \$3144.00/day. The requestor billed \$2280.00/day.

III. RATIONALE

According to the Commission's *Medical Fee Guideline*, CPT code 99352 – Home visit for the evaluation and management of an established patient which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity has a MAR of \$63.00. The requestor did not document at least two of the three key components to support billing per MFG, therefore, no reimbursement is recommended.

CPT code 99499 – Unlisted evaluation and management service is a DOP code.

Modifiers H1 to H4 are used to indicate if the services were rendered by a RN = H1; LVN = H2; CAN = H3; and H4 = other HCP, eg. Occupational Therapist, Physical Therapist, Speech Therapist). The requestor utilized all four modifiers, H1, H2, H3 and H4, with CPT codes 99352 and 99499.

Section 413.011(b) of the Act states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The requestor submitted a standard rate billing by home health agencies located in the Denton/DFW area. The requestor did not submit what they are typically paid. The requestor failed to submit supporting documentation that amount billed and paid by other agencies were for similar treatment, diagnosis code 344.01.

The requestor failed to submit medical records to support fee dispute and challenge insurance carrier's position per Section 413.011(b). Therefore, reimbursement is not recommended.

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement for CPT code(s) 99352H1-4 and 99499H1- H4.

The above Findings and Decision are hereby issued this 6th day of May 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division